CENTER FOR YOUTH WELLNESS
health begins with hope

March 22, 2019

To: DHCS
From: Center for Youth Wellness
Re: Public Comment on DHCS's Prop 56: Trauma screening proposal

We applaud the Administration's demonstrated commitment to improving the quality of health care for children. We also support the proposal to use Prop 56 funds to implement ACEs screening, and provide additional recommendations below that would ensure these proposals best achieve their intended objectives, and improve the health of children and adolescents.

The Center for Youth Wellness is a non-profit engaged daily in pediatric healthcare, mental health and care coordination services, and clinical research and innovation. Our focus is transforming the way society responds to kids exposed to significant adverse childhood experiences and toxic stress. Not only have we supported ACEs screening and intervention through pediatric primary care and an integrated model of care in our own site for over a decade, but we have worked with hundreds of practices seeking to do the same as part of our National Pediatric Practice Community on ACEs.

The following comments complement those we provided in coalition with First 5 Association of California, California Children and Families Foundation, First 5 Los Angeles, Children Now, The Children's Partnership, California Children's Trust, Center for Youth Wellness, Silicon Valley Community Foundation, and Children's Institute of Los Angeles.

While we fully endorse the comments in that letter, **we submit these additional comments to the trauma screening proposal, to articulate more specific recommendations based on our clinical and research experience at the Center for Youth Wellness and the latest evidence pertaining to toxic stress and health outcomes.**

Our experience and the science both indicate that successful implementation and wide-scale adoption of ACEs screening and toxic stress management requires: (1) provider training, (2) care coordination and effective referral systems, and, (3) access to mental health services, including children without symptoms or diagnoses required by current eligibility criteria.

In addition to the already proposed provider supplemental payments, we urge DHCS to pursue activities in support of a successful ACEs screening program for the state:

Provider training on ACEs screening implementation and ACEs- and trauma-informed care - Few medical schools or residency programs include this topic in their curricula. Therefore, it is essential to couple rollout of screening with implementation training and resources for all active providers and trainees. Practices will need support to ensure their staff are appropriately prepared to implement ACEs and trauma-informed services.

Care coordination and effective referral systems - A primary concern of medical providers who want to adopt ACEs screening is whether the families they serve will be able to access intervention and support services. Care coordination within clinics as well as county level systems that support access are crucial to ensure quality patient care and improve outcomes.

Review eligibility requirements for intervention services - ACEs screens should be used to inform practitioners' interactions with patients, referrals, and increase urgency when connecting families to services. Our clinical and research experience coupled with the literature indicate that *any positive ACEs screening score on the PEARLS tool should be used as a new, independent eligibility criteria for patients to access mental health services*.

Research has continuously established a strong association between exposure to childhood adversity and increased likelihood of psychiatric disorders, violence, and/or suicide in teens and adults. There is clearly a dose–response relationship with increasing number and severity of adverse childhood experiences corresponding to these and other poor mental health outcomes. In one study of 137,000 students in 6th, 9th, and 12th grade, more than 1 in 4 reported at least 1 adverse childhood experience. "Each type of adverse childhood experience was significantly associated with adolescent interpersonal violence perpetration (delinquency, bullying, physical fighting, dating violence, weapon-carrying on school property) and self-directed violence (self-mutilatory behavior, suicidal ideation, and suicide attempt). For each additional type of adverse event reported by youth, the risk of violence perpetration increased 35% to 144%." (Duke 2010).

What's also clear is that some children with ACEs will have no symptoms and still be at risk for poor mental health and violence perpetration. This makes sense biologically, as we learn that the dysregulated "fight or flight" stress response, known as toxic stress, can make some children "freeze". In our clinical experience, only further assessment by mental health professionals may uncover symptoms. Psychoeducation about how ACEs, toxic stress, and trauma impact our biology often reveal that certain challenges previously not thought of by parents and pediatric providers as symptoms are actually symptoms of toxic stress. Examples include issues with sleep, nutrition/mealtimes, and exercise.

At the same time, care should be taken to ensure that access to mental health services remains for those who do not have ACEs, but meet other eligibility requirements. Aligned with the

approach outlined in the Governor's proposed budget released in January, the Department should engage with early childhood, ACEs, behavioral/mental health, and healthcare experts to learn from emerging evidence, like that shared above, and make recommendations on how screening results can best inform practice, appropriate referral processes, eligibility, and oversight mechanisms.

Thank you for giving us the opportunity to comment on the screening proposal. If you have any questions, please contact Sara Marques at smarques@centerforyouthwellness.org.

James H. Hickman, CEO
Center for Youth Wellness